Case Number:	CM14-0118911		
Date Assigned:	09/24/2014	**Date of Injury:**	05/05/2014
Decision Date:	11/05/2014	**UR Denial Date:**	07/22/2014
Priority:	Standard	**Application Received:**	07/29/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgeon and is licensed to practice in Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 60-year-old female who reported an injury on 05/05/2014 due to an unknown mechanism. Diagnoses were lesion of ulnar nerve and carpal tunnel syndrome. The physical examination on 07/09/2014 revealed complaints of right hand pain, numbness, and hypersensitivity. The numbness was reported to be constant and it involved the thumb, index, middle, ring, little, and ulnar side of the hand. Pain was reported as sharp. It was also reported that the injured worker has had these problems for a couple of years but they were getting worse. On the left hand was very mild paresthesia only in a carpal tunnel distribution. The injured worker had a previous right carpal tunnel release in 2001 and a left carpal tunnel release and ulnar nerve decompression at the elbow in 2009. The injured worker had a nerve conduction study on 05/05/2014 that revealed evidence of a right median neuropathy at the wrist involving myelin of sensory and motor fibers consistent with a right mild carpal tunnel syndrome. There was evidence of bilateral ulnar neuropathy at the elbows that involved myelin of motor fibers consistent with a bilateral mild ulnar neuropathy. The assessment was right cubital tunnel syndrome and carpal tunnel syndrome. The examination of the hands revealed intrinsic strength - thenar 5/5, hypothenar 4/5. Tinel's at the cubital tunnel and carpal tunnel was positive. Elbow range of motion was within normal limits and stable. The treatment plan was for surgery. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Right Ulnar Nerve Decompression, Right Carpal Tunnel Release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271; 45-46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 25-26 270-271.

Decision rationale: The decision for right ulnar nerve decompression, right carpal tunnel release is not medically necessary. The California American College of Occupational and Environmental Medicine (ACOEM) states regarding ulnar nerve entrapment (including cubital tunnel syndrome), it is possible to entrap a nerve at any point along its course. There are 2 main areas for entrapment of the ulnar nerve at the elbow. The first is in the condylar groove and the second begins immediately distal to the elbow joint in the true, anatomic cubital tunnel. This tunnel commences as the ulnar nerve begins to traverse distally beneath the aponeurosis. Proper testing to localize the abnormality involves a nerve conduction study that includes at least stimulation above and below the elbow (American Association of Electrodiagnostic Medicine 99). There is sufficient evidence, these treatment options are recommended: elbow padding; avoidance of leaning on the ulnar nerve at the elbow; avoidance of prolonged hyperflexion of the elbow; and although not particularly successful for neuropathic pain, utilization of NSAIDs. It was not reported that the injured worker had tried the recommendations of elbow padding and avoidance of leaning on the ulnar nerve at the elbow. The injured worker did have a nerve conduction velocity test, but electromyography testing was not done. Conservative care modalities were not reported such as physical therapy, acupuncture, home exercise program, or injections. Furthermore, the examination of the right elbow reported range of motion with no other objective findings reported. The California American College of Occupational and Environmental Medicine (ACOEM) states for carpal tunnel syndrome, surgical decompression of the median nerve usually relieves carpal tunnel symptoms. High quality scientific evidence showed success in the majority of patients with an electrodiagnostically confirmed diagnosis of CTS. Patients with the mildest symptoms display the poorest post surgery results, patients with moderate to severe CTS had better outcomes from surgery than splinting. CTS must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. Conservative care modalities were not reported such as physical therapy, acupuncture, splints, or injections. The injured worker did not have an EMG study done, only NCV. It was not reported that the injured worker had failed conservative care such as physical therapy, acupuncture, wrist splinting, or chiropractic sessions. Conservative care has not been met for either procedures. The clinical information submitted for review does not provide evidence to justify right ulnar nerve decompression or right carpal tunnel release. Therefore, this request is not medically necessary.